DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Indian Health Service
Rockville MD 20857

DEC 15 1992

SGM 92-4

TO:' Area Directors
Area Contract Health Services Officers

FROM: Director

SUBJECT: Organ Transplant Registry

Beginning October 1, 1992, the Office of Health Programs (OHP) will maintain a formal Organ Transplant Registry for all Indian Health Service (IHS) eligible patients who are referred for possible transplantation of heart, liver, or bone marrow.

Organ transplants are the single most expensive item for which we expend contract health services (CHS) funds. For a number of reasons, accurate information concerning the referral and payment for major organ transplant procedures has not been readily available. The Registry will provide centralized data that will allow for improved monitoring and planning.

Effective January 1, 1993, it will be required that all patients referred for a pre-transplant evaluation or for transplant surgery of the heart, liver, or bone marrow have a Transplant Registry Form completed. All IHS eligible patients, retroactive to October 1, 1992, should be registered, regardless of the source of payment. The instructions and process are detailed on the back of the form.

It will be the responsibility of the clinical director of each service unit to communicate with local or Area CHS staff to ensure this process is functional, and that the information submitted is accurate. The required data should be routed to the Area CHS Officer, who will be the lead OHP contact.

Questions regarding the Transplant Registry should be directed to Stephen W. Heath, M.D., M.P.H., Risk Management Director/Medical Consultant, OHP, on (301) 443-3024.

Everett R. Rhoades, M.D.
Assistant Surgeon General

Attachment

INSTRUCTIONS

General: This form is to be used for all IHS patients referred for HEART, LIVER, or BONE MARROW transplant evaluations, transplant procedures, or to provide follow-up information, whether or not the IHS is responsible for payment. Please submit a separate form for each patient at the time of pre-transplant evaluation, within 2 weeks post transplant, at 6 months and one year post transplant, or when payment Information becomes available. Fill in as-much information as possible. The REGISTRATION NUMBER will be assigned by Headquarters. PRINT or TYPE all entries.

l&2. Fill in the Patient's service unit and IHS Area.

3. Fill in the date the form was completed.

Fill in the name of the Area CHSO or other contact person who is filling out the form.

5&6. Give the full name and SSN (if known) of the patient.

7. Patient's date of birth.

8. Male (M) or Female (F).

9 Fill in the complete diagnosis from the medical record or referral form.

10. If the patient has an alternate resource, circle the appropriate category.

11. Name the physician or facility that actually referred the patient to the transplant center. If the patient was sent from a private hospital or physician, so state.

12. Circle which transplant the patient is being referred for. if another major organ transplant is being performed, name the organ. DO NOT use form for KIDNEY transplants.

13. Fill in this Section If the patient is being referred only for a pre-transplant evaluation. Fill in the name of the facility and the date of the evaluation. indicate whether or not the facility is a Center of Excellence (leave this blank if form is being used prior to the Center of Excellence contract being awarded).
Center of Excellence, indicate whether or not a contract exists with the facilii.

14. Fill in this Section if the patient is being referred for a transplant. Fill in the name of the facility and the date of the transfer. Fill in date of transplant, if known. Indicate whether or not the facility is a Center of Excellence (leave this blank if form is being used prior to the Center of Excellence contract being awarded).
is not a Center of Excellence, indicate whether or not a contract exists with the facility.

15. If IHS is expected to be the predominant payor, fill in anticipated costs, if known. If expected costs are not known, indicate if IHS will be paying "billed charges", "percent of billed charges", 'medicare rates", etc. Complete the Actual Costs column when information is available. If alternate resources pay, try to obtain the amount paid Designate the payor (e.g. IHS, Medicare, etc)

16. Give status of patient at time form is filled out. If the form is being used only to provide an update on the patients status, and previous detailed information has been submitted, you only need to fill in Sections 1-8 and Sections 15-16.

Comments or explanatory remarks may be submitted on a separate piece of paper

For questions, call the Office of Health Programs (301) 4433024. FAX completed forms to (301) 2276213, or mail to office of Health Programs, Parklawn Building, Room 6A-55, 5600 Fishers Lane, Rockville, MD, 20857.

HQ REGIS NO:_____

IHS TRANSPLANT REGISTRY --HEART/LIVER/BONE MARROW

SERVICE UNIT _____ 2. AREA. _____

3. DATE_____ 4. CONTACT PERSON _____

5. PATIENT NAME_____ 6. SSN:_____

7. DATE OF BIRTH_____ 8. SEX_____

9. DIAGNOSIS: PRIMARY_____
SECONDARY_____

10. ALTERNATE RESOURCES: MEDICARE MEDICAID PRIVATE OTHER_____

11. REFERRING PHYSICIAN/FACILITY_____

12. TYPE OF TRANSPLANT: HEART LIVER BONE MARROW OTHER_____

13. REFERRED FOR EVALUATION:

NAME OF FACILITY_____

DATE OF EVALUATION_____

CENTER OF EXCELLENCE: YES NO
IF NO, GIVE REASON _____

CONTRACT FACILITY: YES NO

14. REFERRED FOR TRANSPLANT:

NAME OF FACILITY_____

TRANSFER DATE_____ TRANSPLANT DATE_____

CENTER OF EXCELLENCE: YES NO
IF NO, GIVE REASON _____

CONTRACT FACILIN: YES NO

15. COST INFORMATION, IF KNOWN:

	Anticipated Costs	Actual Costs	Payor
ORGAN	EVALUATION		
	PROCUREMENT		
	TRANSPLANT		
	FOLLOW-UP		
	TOTAL		

16. PATIENT STATUS:

ALIVE DATE_____
-DIED PRE-TRANSPLANT DATE_____
-DIED POST-TRANSPLANT DATE_____